NH Department of Health & Human Services Medicaid Managed Care: Assessing the Potential in NH

Senate Finance Committee
February 17, 2011
Katie Dunn, MPH
Medicaid Director

What is Managed Care?

- Managed care is an approach to delivering and financing health care by providing coordinated services to a group of enrollees through a network of providers and by managing the utilization of health care services.
- Multiple managed care strategies for organizing and financing care.
  - Traditional managed care: Full and Partial Risk Bearing
  - Administrative Services Organization (ASO)
  - Accountable Care Organization (ACO)

Types of Managed Care

- **Primary Care Case Management: (PCCM):** Primary care practitioner receives a monthly case management fee per patient to coordinate care and make referrals to specialty care. Services reimbursed fee-for-service.
- **Patient Centered Medical Home (PCMH):** Similar to PCCM, but with greater expectations of the practice. "A model of care provided by physician practices that seeks to strengthen the physician-patient relationship by replacing episodic care…with coordinated care." (NCQA)
- **Managed Care Organization (MCO):** A MCO which assumes responsibility for a global budget, outcomes, insurance risk, and claims processing.
  - **Partial Risk Contracting:** MCO agrees to provide some, but not all services for a set amount per person per month (PMPM). Some services continue to be reimbursed on a fee-for-service basis. Or provider limits risk to a corridor around a targeted amount. An example of a corridor is a cost sharing/gain around +/- 10% of a target amount.
  - **Full risk contracting:** MCO agrees to provide all services for a set amount PMPM basis (full capitation). The contractor is at risk for costs that exceed the capitation. Contracts often include risk adjustment based on the health status and resource use of their enrollees to protect plans from excessive risk.
- **Administrative Service Organization (ASO):** A contractor that assumes responsibility for specific administrative services focused on utilization management and/or care management. Contractor at risk for process outcomes and/or health outcomes appropriate to the scope of work.
- **Accountable Care Organization (ACO):** A provider organization that assumes accountability for a global budget and health outcomes for a specific population and services.

Why States Adopt Risk-based Contracts and other Global Budget Approaches

- Improve accountability and measurement of quality of care, health status, and outcomes
- Reduce per member cost
- Make expenditures more predictable
- Align incentives of payers, providers, and members

Managed Care Federal Authority

Eligibility Group	Voluntary Enrollment	Mandatory Enrollment
Parents and children	State Plan Amendment	State Plan Amendment
Elderly and Disabled Adults	State Plan Amendment	State Plan Amendment
Dually eligible, special needs children	State Plan Amendment	Section 1915(b) or 1115(b) waiver

DHHS finds that it will be possible to receive federal permission to implement risk-based managed care contracts. The range of federal authority options goes from easier to obtain with trade off of fewer design options to harder to obtain with more design options.

CMS Managed Care Requirements for Full Risk Contract

- State must provide beneficiary a choice of not less than 2 entities.
- Individuals must be permitted to terminate or change enrollment for cause at any time; without cause 90 days from enrollment or at least every 12 months thereafter.
- State must present individuals with comparative information chart on each MCO.
- Beneficiary protections include access to emergency services, provider-enrollee communications, grievance procedures, demonstration of adequate capacity and services.
- State must have a Quality Improvement assessment and improvement strategy that includes contracting with an EQRO.
- MCO may not directly distribute marketing materials to beneficiaries.
- PMPM rates must be certified by independent actuary and approved by CMS as "actuarially sound."

Other State Medicaid Programs

- Variety of care management programs pursued
  - PCCM and capitated MCO forms
  - Programs often not statewide, do not include all eligibility groups, and are not comprehensive in services included.
  - Even with managed care, states continue to wrap around coverage and carve out services for separate management.
  - Connecticut dropping full risk managed care contract. "Too expensive".

Literature Review: Summary of Risk-based Medicaid Managed Care Outcomes

- The preponderance of peer-reviewed literature reports that managed care is associated with…
  - Greater likelihood of a usual source of care for members
  - Less emergency department use
  - Reduction in preventable hospital admissions
  - Greater smoking cessation and prenatal care among pregnant women and
  - Greater use of community services, and less use of institutional services among people with long-term supports needs.

Lessons Learned From Other States

- Must adapt to local conditions – full risk contract may not be possible throughout state.
- Engage stakeholders early and continuously.
- Need 3-5 year commitment to see program mature.
- Measure performance which requires early attention to data gathering and attention to analysis.
- Build effective administrative infrastructure: contract development & monitoring, federal reporting, quality monitoring.
- First year MCO rates reasonable. Subsequent years rates increase substantially to account for investment in provider network reimbursement and infrastructure. Administrative overhead costs to MCO 11% – 15%.

NH's Voluntary Managed Care Program

- NH Medicaid had a *voluntary* managed care (VMC) program for TANF population only from 1999 to 2003.
- Began with 3 insurers. By 2003 only 1 response to RFP due to inability to maintain provider network due to rates needed to retain providers.
- Actuaries looked at actual SFY 01 and 02 benefit utilization data compared to premiums paid.
- VMC costs at that time were higher than adjusted FFS costs and it would cost the state much less than the 12-15% to administer the same services under FFS.
- Elimination of VMC resulted in $8M in savings that was used to close budget deficit and respond to dental lawsuit.

Current Day NH Medicaid Managed Care Strategies

- Efforts to date have focused on medical services. Have not included behavioral health and LTC/Home & Community Based services.
- Progress to implement managed care has been informed by decisions of NH Legislature
  - Pharmacy Benefit Manager (Magellan)
  - Disease Management (1915 waiver) (McKesson)
  - Enhanced Care Coordination Pilot (Schaller)
  - Preferred provider contracting e.g. diabetes supplies
  - Application of Evidence Based Guidelines
  - Utilization Management (prior authorization, service limits, inpatient review, discharge planning)
  - Physician profiling and detailing
  - Quality Assessment and Improvement
- Bureau of Behavioral Health Initiative
  - Developing pre-paid plan with capitated payments for CMHCs
  - Leverage and integrate work completed to date.

National Findings on Savings

- Savings range from 0.5% to 20%
- Dependencies:
  - Efforts state has taken to manage care through initiative such as PBMs and utilization management strategies
  - Savings greater in urban vs. rural areas
  - Savings greatest for older persons and persons with disabilities than for parents and children
  - Savings greater in risk-based than in PCCM
  - Savings derive primarily from reducing hospital use
- OMBP's Milliman Study: 0% - 5% maximum with higher end based upon including all populations due to managed care strategies DHHS has already put in place.

Factors Affecting Savings

- Scope of care management
  - Who and what services/diseases/conditions managed?
- Intensity and coordination of care management
  - Role of PCP, single case manager, telephonic vs. in person?
- Active provider network development
  - Training and implementation of PCPs as care managers.
- Geographic coverage of services areas
- How program rolled out
  - Phase in or statewide?
  - Start date of program
- How will the program affect PCP behavior?
  - Changed practices or just better willingness to accept Medicaid beneficiaries as regular patients?
- Amount of attention paid to contract definition and rates paid for care management activities.

Results of Managed Care Request for Information

- 12 responses were received (with 10 answering all or most of the questions).
- Nine respondents were Health Maintenance Organizations or Managed Care Organizations; two were Administrative Service Organizations (although both performed some functions of a HMO/MCO), one response was a letter of concern, providing no feedback for program design.
- Of nine HMOs/MCOs, six were for-profit national firms; three were New England regional not-for profit entities.
- For risk-based arrangements, one respondent indicated using full capitation for all services, the rest used a broader array of payment methods (risk/incentive arrangements for either a limited number, half, most, or all of their services).
- None of the respondents discussed the impact Medicaid Managed Care might have on rural areas.

Additional Factors to Consider Making Decision to Transition to Full/Partial Risk Financing

- Requires up front investment including claims run out period. ($85M GF).
- Enrollee access to primary care providers & specialists is highly dependent on the MCO provider network & reimbursement rates.
- Cost containment efforts can result in decline in quality of care if payments to MCOs are not tied to performance & quality measures.
- Significant federal regulations for capitated managed care program.
- Contract with MCO still requires administrative resources to perform fiduciary, reporting, and quality oversight functions.
- Need to explore other options given that NH Medicaid has been engaged in managing care for a number of years.

NH DHHS Objectives
In Considering Next Steps

- Improve beneficiary health and/or prevent further deterioration in health status.
- Reimbursement for effective and efficient health care through payment for improved health outcomes thereby maximizing the value of each dollar spent on the care of Medicaid beneficiaries.
- Support continuity of care *through* coordination across all DHHS and medical systems of care including state plan, behavioral health and long-term care waiver services.
- Assuring timely access to preventive care.
- Assuring the appropriate site of service.
- Preventing avoidable admissions and readmissions.
- Promote shared decision making.
- Improved budget predictability
- Consider longer term 2014 Medicaid expansion.

NH Medicaid's Next Steps…

- Focus on the design, development, and implementation of reimbursement strategies for/to support a comprehensive managed care health care delivery system.
- SB 147-FN: Mandatory Medicaid Managed Care
  - An instrument supporting the change DHHS is seeking.
  - DHHS has suggestions to further refine the bill as it makes its way through the legislative process to ensure that it best meets the needs of the NH Medicaid program.

Maine's Implementation Cost Estimates

Task	Match	Yr 1 Planning General Funds (000's)	Yr 1 Planning Total (000's)
Stakeholder engagement	50/50	$ 250	$ 500
Model design	50/50	$ 250	$ 500
State Plan Amendments/Waivers	50/50	$ 250	$ 500
RFP; Issue & Evaluate	50/50	$ 250	$ 500
Actuarial rate development	50/50	$ 375	$ 750
Information Systems Updates	90/10	$ 100	$ 1,000
Quality Program Development	50/50	$ 240	$ 480
Enrollment Broker	50/50	$ 125	$ 250
Contract Development/Management	50/50	$ 125	$250
TOTAL Implementation Costs, FY 11		$ 1,965	$ 4,650
Reallocation of existing contract & staffing resources	50/50	($ 425)	($ 850)
Net New Needs, FY 11		$ 1,540	$ 3,800

Maine's Illustrative Ongoing Managed Care Operational Costs

Tasks	State Resources	Outside Resources	Match Rate	State Funds (000's)	Total Funds (000's)
Define Operational Model	√	√	50/50	$ 150	$ 300
Stakeholder Engagement	√	√	50/50	$ 50	$ 100
Development & Submission of State Plan Amendment/Waiver	√	√	50/50	$ 50	$ 100
Rate Development		√	50/50	$ 125	$ 250
Additional Operational Updates	√	√	75/25	$ 50	$ 200
External Quality Review Organization (EQRO)	√	√	60/40	$ 140	$ 350
Enrollment Broker		√	50/50	$ 50	$ 100
Contract Development & Management	√		50/50	$ 100	$ 200
Subtotal annual operational costs Savings on existing care management, assessment and utilization review **Net annual operational savings**				$ 715 ($ 2,100) ($ 1,385)	$ 1,600 ($ 6,300) ($ 4,700)